Nevada State Health Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4961AGZ	A. BUILDING: _____ B. WING _____	C 06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
7TH HEAVEN	1205 PONCE DE LEON AVE LAS VEGAS, NV 89123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 5/30/12 through 6/13/12. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for seven Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. Complaint #NV00031904 - The allegation regarding failure to report a change in condition to a family member was substantiated. See TAG Y0850. The allegation regarding neglect of a resident was unsubstantiated through interviews and record review. #NV00031904: The complaint investigative process was initiated by the Bureau of Health Care Quality and Compliance on 5/30/12. The investigation for the allegation regarding neglect of a resident included: -Interviews were conducted with the facility administrator, hospice care providers, home health care providers, and an administrator at another facility.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 000	Continued From page 1 -Review of hospice care records, home health care records, and the resident's medical records. The investigation of the allegation regarding failure to report a change in condition to a family member included: -Interview was conducted with the facility administrator. -Review of the resident's file at the facility.	Y 000		
Y 850 SS=E	449.274(1)(a) Medical Care of Resident NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. 1. If a resident of a residential facility becomes ill or if injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident's physician is not available.	Y 850		

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Y 850	Continued From page 2 This Regulation is not met as evidenced by: Based on record reviews and interviews from 5/30/12 through 6/13/12, the facility failed to notify a family member of one of three residents when a change in condition occurred (Resident #1). Severity: 2 Scope: 2	Y 850		